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AUTHOR Graham, Mary Jo
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ABSTRACT

The Children's Center in Institute, West Virginia integrates disabled preschool children with their non-disabled peers. This integration is the result of a merger between programs of two private non-profit agencies. Through the assistance of an interagency coordination council, the two programs--a mental health agency's early intervention program and a child development agency's child care center--became aware of their common interests and needs. In forming a cooperative agreement, the agencies integrated their philosophies, staff, and children. Cognitive psychology and the work of Piaget provided the necessary unification of the developmental model and the interventionist model. Through regularly scheduled staff meetings, staff learned new techniques to use with children and clarified policies and procedures. Teachers integrated goals on the individual education plans (IEPS) of disabled children into lesson plans for the classroom. Therapists and other professionals conducted therapies in the classroom. Through creative planning, all children are included in all activities. Special equipment in the classroom is borrowed from its two parent agencies or donated by philanthropic organizations. Children in the program have shown the same general progress that children in other high quality programs do. Children show a high level of empathetic behaviors such as assisting others and comforting others. Progress for children with disabilities has been greater than projected. The program may not be appropriate for children with severe behavior disorders. (KS)

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INTEGRATING PRESCHOOL PROGRAMS AND PRESCHOOL CHILDREN

by

Mary Jo Graham

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INTEGRATING PRESCHOOL PROGRAMS AND PRESCHOOL CHILDREN

Mary Jo Graham
River Valley Child Development Services
1448 Tenth Avenue
Huntington, WV 25701

ABSTRACT

Early childhood programs are often inaccessible for children who are disabled. At Children's Center, children who have disabilities are fully integrated with children who are not disabled. Children's Center was created when two private non-profit agencies merged individual programs with a cooperative agreement which pooled the resources of each agency. The merger required integration of two areas: the program including philosophy, purposes, and personnel and the practices including planning, implementing and evaluating services for children. This paper describes the process of pooling resources and integrating services.

TEXT

Child care is a necessity for a majority of today's families. Two thirds of all children under the age of six have mothers in the labor force.[1] The need for child care has increased rapidly resulting in a shortage of quality child care. Many families have considerable difficulty in locating programs which meet their needs. Families who have children with special needs experience even greater difficulty in locating needed early childhood programs.[2]

There is a tendency to assume that integrating children with disability requires funding and expertise far beyond that of the average independent early childhood program. The typical day care director or preschool administrator is usually very concerned that their program may not be able to adequately meet special needs and offer a beneficial experience to a child with profound disability. Independent programs lack confidence in their ability to serve children with disabilities and have limited financial resources for special equipment and consultation.

Federal legislation which has mandated that persons with disability have equal access to the least restrictive environment has provided an impetus for early childhood educators to seek ways of including children with disabilities in programs for young children. Public programs such as Head Start have been integrating children with special needs since 1972 but they are limited in the number of children they can serve.[3] When children have mild to moderate disabilities, inclusion in programs can be done with minor adjustments. However, for those with more severe disabilities, integration in programs which serve children without disabilities has been more difficult to accomplish.[4]

How then can accessibility to early childhood programs be increased for children with disabilities in a system of early education which operates privately and independently? The purpose of this paper is to share the process of integrating children with and without disabilities that occurred when two private non-profit agencies pooled their resources to establish Children's Center in Institute, WV. This merger required integration on two levels. First, it was necessary to integrate the philosophy, purposes and personnel of the cooperating programs. Second, children were integrated through planning, implementing and

evaluating services. The process of integrating each area will be described. The experience in creating Children's Center is offered as guidance and inspiration to those who attempt similar efforts to integrate children.

INTEGRATING PROGRAMS

Merging purposes. The merger of an early intervention program operated by a non-profit mental health agency and a child care center administered by a non-profit child development agency came about when each agency realized that the other had the answer to their needs. The mental health agency recognized the need for child care among their families. Families were finding it difficult to locate centers who would enroll their children with disabilities. The child development agency had a small child care center in the area and was willing to enroll children with disabilities but lacked the space to do so. Since the mental health agency had unused space, an agreement was developed to cooperatively operate a day care center which would integrate children with and without special needs.

Perhaps the most important step in the process was the recognition that each agency had common interests and needs. It was through service on a statewide council that the directors of each program discovered their mutual interests. Agencies can often function in isolation never knowing what is shared in common with others. There can be a sense of "turf" among agencies who provide similar services and often these agencies compete for limited funding. Attempts to increase the communication among independent agencies can be quite productive when barriers are broken down and common interests are discovered. For example, at a local level, an interagency coordinating council which meets monthly to share information about services or needs and to plan community awareness events and training opportunities is an excellent way to inspire cooperative arrangements.

A cooperative agreement is the first step in merging programs. It serves as a guide for the organization and implementation of a joint effort. Each agency must identify what can be contributed in the way of equipment, staff, expertise and facility. Projected budgets must be established that will determine the probability of survival. This is a tedious process. Defining responsibilities can be as major as who supervises whom and as mundane as who buys the bathroom tissue. The cooperative agreement cannot be thought of as a finished document however. Once implementation begins, there will be unexpected needs that arise and better organizational techniques will become apparent. A process for modifying the agreement is essential.

Merging philosophies. The most basic issue in forming a cooperative agreement is that of philosophy. Similar philosophies are more likely to merge successfully. In the case of Children's Center it was necessary to blend two approaches: the developmental model and the interventionist model.[5] There are some distinct similarities in these two approaches. Both emphasize the uniqueness of the individual and the need to work individually with children. Both advocate for the dignity of all children and insist upon patience and courtesy when working with them. Optimal development is the goal of both methods.

There are, however, some basic differences which have had to be ironed out to complete a successful merger of the developmental and interventionist philosophies. The developmental approach emerged at the turn of the century from the early kindergarten movement, the child study movement and psychoanalytic theory. Developmental programs view children as intrinsically motivated to actively explore the environment and the need to practice developmental tasks through direct experience. Teachers are required to know normal developmental stages and to be able to facilitate the child's development by providing an environment that stimulates curiosity and encourages independence. The traditional developmental approach leans heavily toward maturation and heredity as fundamental to growth.

The interventionist model is a product of the field of special education. While special education emphasizes remedial, corrective, and adaptive functions for older children, intervention and prevention are the emphasis in the early childhood years. Early interventionists believe that disabled children can be taught to function independently, compounding disabilities can be prevented, and capabilities can be increased. Having roots in compensatory education and behaviorism, the interventionist attempts to alter the course of development through intensive individualized instruction.

The traditions inherent in the developmental and interventionist philosophies do result in differences in classroom practices. While the developmental teacher would provide a stimulating classroom and encourage children to actively participate, the interventionist would identify specific behaviors to be learned and direct the child toward those behaviors. The developmental classroom is child directed while the interventionist classroom is teacher directed. Some children with mild to moderate disabilities do quite well in a classroom of nondisabled peers with no special adjustments or direct teaching. However, the more profoundly handicapped may not respond at all to the classroom environment without intervention.

Cognitive psychology and particularly the work of Piaget provides the necessary unification of developmental and interventionist philosophies by identifying an ultimate goal of child initiated interactive learning. A teacher who understands development can watch for the expected interactions with the physical and social environment. When appropriate interaction is not present, a teacher first determines if there are any barriers present and eliminates those barriers. Teachers then increase direction as needed through such techniques as modeling, prompting, and behavior modification. It is important to begin with the least directive method and move to greater involvement. As interactions with the environment increase to an appropriate level, a teacher's involvement should decrease to that of a planner and facilitator.

While some children do require directed experiences, a classroom which is totally teacher directed can deprive children who can and do initiate learning of many quality learning experiences. Children may need direction in some areas and not in others. The question for teachers is to determine when to direct learning and when to allow child initiated activity to proceed.

Merging personnel. The parent agencies of Children's Center were both able to contribute staff to Children's Center. Staff who worked in the day care center had not had extensive training with children who had severe handicaps. Staff who had worked in the early intervention program were not highly experienced with nondisabled children. Both staffs were uncomfortable with the new challenges and new colleagues. Active communication was essential. Regularly scheduled staff meetings within rooms and with the entire staff as well as administrative meetings were the most effective tools in establishing and maintaining good communication. This was also the most time consuming and demanding part of the merger.

Through established communication channels, staff learned new techniques to use with children and clarified policies and procedures. When problems occurred, there was an opportunity to develop solutions. While staff learned their new roles, unity was created as the similarity among all children became apparent. Children with disability were discovered to be at a particular stage of development and were needing to move to a new stage as did the children without disabilities. Children without physical or mental disabilities also were found to have special needs unique to each individual. Recognizing the uniqueness of all children and accepting a wide range of diversity in an individualized setting became the foundation of an effective program.

INTEGRATING CHILDREN

Planning. Most professionals are accustomed to having a specific role to play in the life of a child and are quick to refer a child to another agency when a need outside their realm appears. A child with disabilities will commonly visit a case manager in one place, a physical therapist in another, a speech therapist at still another place, and a physician in yet a different setting. Parents who have children with disabilities spend their lives going to appointments. Only the persistent highly motivated parent will follow through.

One of the goals set for Children's Center was to cut down on some of these time consuming visits. This is extremely important for parents who must work all day, although such disconnected services can be just as overwhelming to a parent who stays at home.

Both teachers at Children's Center have been assigned the task of maintaining an individual education plan (IEP) for each child with special needs. The teacher collects information from the specialists in the child's life which can include physical therapists, occupational therapists, speech therapists, early interventionists, case managers, psychiatrists, psychologists, and physicians. The teacher then determines what can be reasonably accomplished in the group setting for a child and sets developmental goals on the IEP. As the teacher notes that a child has accomplished a goal, new goals are planned.

When the teacher is developing lesson plans for the classroom, the goals on the IEP are integrated into the planning. This is not all that cumbersome in a developmentally appropriate classroom. None of the children are expected to work at the same activity at the same time in the same way. For example, the two year old teacher may plan an art project in which she places three different colors of paper pieces on

the table with some glue and larger pieces upon which to glue the colors. The teacher's intention for the majority of the twos may be to use the color names as the children work to help them learn color names. A child who is developmentally delayed may be more interested in the texture of the glue than the names of color, and spend time massaging the glue between fingers. In this situation, the teacher would add words such as wet and sticky. Therefore, all of the children have an opportunity to expand language understanding.

In addition to the integration of specific goals into the normal routine of the day, other professionals are welcomed and encouraged to conduct therapies in the classroom. A speech therapist can utilize peer modeling to develop language abilities in children. Nondisabled children can do the exercises prescribed by a physical therapist along side a child with physical limitations which increases the motivation of the child with disabilities who may find certain procedures unpleasant or bothersome. Also, the therapists can make suggestions to teachers such as ways of positioning children so that strength can be built as the children participate in other activities. Professionals visiting in the classroom are a wonderful resource to staff and their visits can be very reassuring.

Implementing. In actual classroom practices, the goal is to include all children in all activities without differentiating among those with handicaps and those without. This requires considerable imagination, creativeness, and planning. At first, those who had been working with children with handicaps were assigned specific children to assist. However, this created an unspoken psychological barrier for full integration. There was a "mine and yours" attitude toward the work in the classroom. Instead, all staff are now trained to meet special needs and all staff are assigned responsibility for all children in the room. If a child needs assistance, the closest staff person attends to the need. Children are encouraged to help one another. For example, if a child in a wheel chair is wanting to be moved to a floor sitter, the staff person might ask another child to hold a strap out of the way or to get a sand bag from another part of the room. Most children are very responsive to being asked to help and it is not uncommon to see another child respond to a child's need such as adjusting a sandbag or retrieving a dropped object before the teacher can respond.

Young children accept different needs when teachers explain a limitation simply and clearly to an inquisitive child. Children's playful exploration lead them to try out various pieces of special equipment and use dolls in different apparatuses. It becomes routine to push the wheelchair and retrieve crutches. Some children get particular pleasure from teaching others. These "peer tutors" can be seen trying to get a child who doesn't speak to make a sound and then squeal with delight when the child responds. Of course, their reaction is very reinforcing and the child without speech can be heard vocalizing over and over to maintain the attention of their friend.

In order to foster positive interactions among children, those who are immobile or less likely to interact are placed at an activity that is very popular and at a level that is comparable to the other children.

When tables are raised so that a wheel chair can be put under them, the other children do not choose these tables as they are not as comfortable. It is better to keep the tables at a level appropriate for the majority and then plan creative ways to get the child needing support to the table. Everything from pillows and sandbags and cardboard cutouts can help to adjust a chair or a piece of equipment. The important consideration is stability in case active children bump into the equipment. The most severely involved children benefit from close contact with activity. The fussiness of several children who seem to be unaware of the environment has been greatly reduced when they are at the epicenter of classroom activity.

Special equipment such as Rifton chairs, floor sitters and prone standers are very helpful. Children grow rapidly and equipment in different sizes can be expensive. Children's Center has borrowed much of what it has needed from its two parent agencies. Philanthropic organizations and church groups have been willing to make donations to purchase additional equipment. Early childhood programs in an area could designate a central group that would solicit and store such equipment and then would lend it out when children who have a need enroll in a program.

Evaluating. When parents were first approached about the possible merger of the two programs, many were hesitant. Parents who had disabled children and parents of typical children both were afraid that their children may not receive the attention that they needed. Parents were afraid that a child with special needs would be rejected and a child that is not disabled might imitate the behaviors of a less competent child or not be appropriately stimulated. The gradual steady growth of enrollment is proof that these fears have been reduced.

The progress of all the children has been excellent. Children have shown the same general progress that children in other high quality programs do. One characteristic that seems to be more prevalent among the children at Children's Center is a high level of empathetic behaviors such as assisting others and comforting others. Two factors could play a role in this increased ability to empathize. First, families who are more empathetic may be more attracted to the program. Second, children may be seeing more caregiving in the classroom environment to imitate. Casual observations indicate that there is good reason to quantify this characteristic with some controlled studies.

Progress for children with disability has been greater than projected. Again, systematic measures of the differences have not been made but on a case to case basis, there have been changes in children that have not been accomplished in other settings. A child who spent his days crying, stopped crying and began babbling. A child who would not give up a walker, began using crutches. A child who would wait to be picked up now crawls around the room, pulls up on furniture to join activities and is now learning to use a walker. A child who could not use her arms can feed herself and play in sand and water with other children. No one can know for certain whether these activities would have been accomplished in other settings, but those who have known these children for a period of time have been surprised by their progress.

One area that has remained a nemesis is that of children with behavior disorders. When behavior disorders are mild to moderate and not highly impacted by environmental stimulation, the developmentally appropriate setting can accommodate the children quite well and have a positive impact on their behavior. However, many children with severe behavior disorders demand one on one attention to keep the child safe and to protect the other children. If the child is easily distracted or loses control there is very little that can be done in the large group setting to improve the child's behavior. It is very important to remember that not all children can be well served in a single program even when the goal is to be comprehensive.

CONCLUSIONS

Early childhood programs will remain inaccessible for many children with special needs unless problems of limited funding, fragmented services and training needs are met. A creative pooling of limited resources is an excellent way in which to solve some of the problems which create barriers to improved services for young children. Children's Center is evidence that existing programs can work together cooperatively. Cooperative agreements must consider the merging of purposes, philosophy and personnel as well as planning, implementing and evaluating provided services. Integration of programs and the children served in those programs is a viable way to develop comprehensive accessible children's programs.

ENDNOTES

1. Phillips, Deborah. (1987). "From a Tattered Patchwork Quilt to a Whole Cloth: Child Care Advocacy for 1987." Dimensions 16:1 (Oct. 1987) 8-10.
2. Weiner, Roberta & Keppelman, Jane. (1987). From Birth to Five. Alexandria, VA: Capitol Publications, Inc., 41.
3. Kagan, Sharon L. (1989). "Early Care and Education." Phi Delta Kappan 71:6 (Feb. 1989) 433-439.
4. Mild and moderate disability is defined as less than a 50% delay in any given area while severe disability refers to a greater than 50% delay in any given area.
5. The following work provided extensive guidance for this process and is largely responsible for the thoughts in this section: Safford, Philip L. (1989). Integrated Teaching in Early Childhood. White Plains, NY: Longman, Inc.